Complete Summary

GUIDELINE TITLE

Clinical guideline on periodicity of examination, preventive dental services, anticipatory guidance, and oral treatment for children.

BIBLIOGRAPHIC SOURCE(S)

American Academy of Pediatric Dentistry. Clinical guideline on periodicity of examination, preventive dental services, anticipatory guidance, and oral treatment for children. Chicago (IL): American Academy of Pediatric Dentistry; 2003. 3 p. [24 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Oral diseases

GUIDELINE CATEGORY

Counseling
Evaluation
Prevention
Risk Assessment

CLINICAL SPECIALTY

Dentistry
Pediatrics

INTENDED USERS

Dentists

GUIDELINE OBJECTIVE(S)

To help practitioners make clinical decisions concerning preventive oral health care for healthy infants, children, and adolescents

TARGET POPULATION

Infants, children, and adolescents who have no contributory medical conditions and are developing normally

INTERVENTIONS AND PRACTICES CONSIDERED

1. Clinical oral examination
2. Assessment of oral growth and development
3. Removal of supragingival and subgingival stains or deposits
4. Scaling and cleaning the teeth
5. Assessment of the appropriateness of feeding practices, including bottle feeding, breast-feeding, and no-spill training cups
6. Caries-risk assessment using caries-risk assessment tool (CAT)
7. Prophylaxis and topical fluoride treatment
8. Fluoride supplementation
9. Providing anticipatory guidance
10. Counseling on the following topics:
    - Oral hygiene (to parents/ guardians/ caregivers and patients
    - Diet
    - Age-appropriate injury prevention
    - Nonnutritive habits (e.g., digit, pacifiers, fingernail biting, clenching, or bruxism)
    - Substance abuse
    - Intraoral/perioral piercing
11. Radiographic assessment
12. Treatment of dental disease/injury
13. Assessment and treatment of developing malocclusion
14. Providing pit and fissure sealants for primary and permanent teeth as indicated
15. Assessment of and/or removal of third molars
16. Assessment of speech and language development and providing appropriate referral as indicated
17. Referral for regular and periodic dental care

MAJOR OUTCOMES CONSIDERED

Not stated

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

These guidelines are a compilation of pediatric oral health literature and national reports and recommendations, in addition to related policies and guidelines published in the American Academy of Pediatric Dentistry (AAPD) Reference Manual. The related policies and guidelines provide references for individual recommendations. Some recommendations are evidence-based, while others represent best clinical practice and expert opinion.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The oral health policies and clinical guidelines of the American Academy of Pediatric Dentistry (AAPD) are developed under the direction of the Board of Trustees, utilizing the resources and expertise of its membership operating through the Council on Clinical Affairs (CCA).

Proposals to develop or modify policies and guidelines may originate from 4 sources:

1. the officers or trustees acting at any meeting of the Board of Trustees
2. a council, committee, or task force in its report to the Board of Trustees
3. any member of the AAPD acting through the Reference Committee hearing of the General Assembly at the Annual Session
4. officers, trustees, council and committee chairs, or other participants at the AAPD's Annual Strategic Planning Session

Regardless of the source, proposals are considered carefully, and those deemed sufficiently meritorious by a majority vote of the Board of Trustees are referred to the CCA for development or review/revision.

Once a charge (directive from the Board of Trustees) for development or review/revision of an oral health policy or clinical guideline is sent to the CCA, it is assigned to 1 or more members of the CCA for completion. CCA members are instructed to follow the specified format for a policy or guideline. All oral health policies and clinical guidelines are based on 2 sources of evidence: (1) the scientific literature; and (2) experts in the field. Members may call upon any expert as a consultant to the council to provide expert opinion. The Council on Scientific Affairs provides input as to the scientific validity of a policy or guideline.

The CCA meets on an interim basis (midwinter) to discuss proposed oral health policies and clinical guidelines. Each new or reviewed/revised policy and guideline is reviewed, discussed, and confirmed by the entire council.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Once developed by the Council on Clinical Affairs (CCA), the proposed policy or guideline is submitted for the consideration of the Board of Trustees. While the board may request revision, in which case it is returned to the council for modification, once accepted by majority vote of the board, it is referred for Reference Committee hearing at the upcoming Annual Session. At the Reference Committee hearing, the membership may provide comment or suggestion for alteration of the document before presentation to the General Assembly. The final document then is presented for ratification by a majority vote of the membership present and voting at the General Assembly. If accepted by the General

Assembly, either as proposed or as amended by that body, the document then becomes the official American Academy of Pediatric Dentistry (AAPD) oral health policy or clinical guideline for publication in the AAPD's Reference Manual and on the AAPD's Web site.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Birth to 12 Months

1. Complete the clinical oral examination with appropriate diagnostic tests to assess oral growth and development, pathology, and/or injuries; provide diagnosis.
2. Provide oral hygiene counseling for parents, guardians, and caregivers, including the implications of the oral health of the caregiver.
3. Remove supragingival and subgingival stains or deposits as indicated.
4. Assess the child's systemic and topical fluoride status (including type of infant formula used, if any, and exposure to fluoridated toothpaste) and provide counseling regarding fluoride. Prescribe systemic fluoride supplements, if indicated, following assessment of total fluoride intake from drinking water, diet, and oral hygiene products.
5. Assess appropriateness of feeding practices, including bottle and breast-feeding, and provide counseling as indicated.
6. Provide dietary counseling related to oral health.
7. Provide age-appropriate injury prevention counseling for orofacial trauma.
8. Provide counseling for nonnutritive oral habits (e.g., digit, pacifiers).
9. Provide required treatment and/or appropriate referral for any oral diseases or injuries.
10. Provide anticipatory guidance for parent/guardian/caregiver.
11. Consult with the child's physician as needed.
12. Based on evaluation and history, assess the patient's risk for oral disease.
13. Determine the interval for periodic re-evaluation.

12 to 24 Months

1. Repeat birth to 12-month procedures every 6 months or as indicated by individual patient's risk status/susceptibility to disease.
2. Assess appropriateness of feeding practices, including bottle, breast-feeding, and no-spill training cups, and provide counseling as indicated.
3. Review patient's fluoride status-including any childcare arrangements, which may impact systemic fluoride intake-and provide parental counseling.
4. Provide topical fluoride treatments every 6 months or as indicated by the individual patient's needs.

2 to 6 Years

1. Repeat 12- to 24-month procedures every 6 months or as indicated by individual patient's risk status/susceptibility to disease. Provide age-appropriate oral hygiene instructions.

2. Complete a radiographic assessment of pathology and/or abnormal growth and development, as indicated by individual patient's needs.
3. Scale and clean the teeth every 6 months or as indicated by individual patient's needs.
4. Provide pit and fissure sealants for primary and permanent teeth as indicated by individual patient's needs.
5. Provide counseling and services (athletic mouthguards) as needed for orofacial trauma prevention.
6. Provide assessment/treatment or referral of developing malocclusion as indicated by individual patient's needs.
7. Provide required treatment and/or appropriate referral for any oral diseases, habits, or injuries as indicated.
8. Assess speech and language development and provide appropriate referral as indicated.

6 to 12 Years

1. Repeat 2- to 6-year procedures every 6 months or as indicated by individual patient's risk status/susceptibility to disease.
2. Provide substance abuse counseling (e.g., smoking, smokeless tobacco).
3. Provide counseling on intraoral and perioral piercing.

12 Years and Older

1. Repeat 6- to 12-year procedures every 6 months or as indicated by individual patient's risk status/susceptibility to disease.
2. At an age determined by patient, parent/guardian, and pediatric dentist, refer the patient to a general dentist for continuing oral care.

Table: Recommendations for Pediatric Oral Health Care

Since each child is unique, these recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal. The American Academy of Pediatric Dentistry (AAPD) emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child.

	6-12 months	12-24 months	2-6 yea
Clinical oral examination[1]	X	X	X
Assess oral growth and development[2]	X	X	X
Caries-risk assessment[3]	X	X	X
Prophylaxis & topical fluoride treatment[4]		X	X

	6-12 months	12-24 months	2-6 yea
Fluoride supplementation[5,6]	X	X	X
Anticipatory guidance[7]	X	X	X
Oral hygiene counseling[8]	Parents/guardians/caregivers	Parents/guardians/caregivers	Patient/parents/guard
Dietary counseling[9]	X	X	X
Injury prevention counseling[10]	X	X	X
Counseling for nonnutritive habits[11]	X	X	X
Substance abuse counseling			
Counseling for intraoral/perioral piercing			
Radiographic assessment[12]			X
Treatment of dental disease/ injury	X	X	X
Assessment and treatment of developing malocclusion			X
Pit and fissure sealants[13]			X
Assessment and/or removal of third molars			
Referral for regular and periodic dental care			

Notes:

1. First examination at the eruption of the first tooth and no later than 12 months.
2. By clinical examination.
3. As per American Academy of Pediatric Dentistry (AAPD) "Policy on the use of a caries-risk assessment tool (CAT) for infants, children, and adolescents."
4. Especially for children at high risk for caries and periodontal disease.
5. As per American Academy of Pediatrics/American Dental association guidelines and the water source.
6. Up to at least 16 years.

7. Appropriate discussion and counseling should be an integral part of each visit for care.
8. Initially, responsibility of parent; as child develops, jointly with parents; then, when indicated, only child.
9. At every appointment, discuss the role of refined carbohydrates, frequency of snacking.
10. Initially play objects, pacifiers, car seats; then when learning to walk, sports and routine playing.
11. At first discuss the need for additional sucking; digits vs. pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.
12. As per the American Academy of Pediatric Dentistry "Clinical guideline on prescribing dental radiographs."
13. For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and/or fissures; placed as soon as possible after eruption.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

All oral health policies and clinical guidelines are based on 2 sources of evidence: (1) the scientific literature; and (2) experts in the field.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Appropriate management of infant, child, and adolescent oral health needs.
- Major benefits of early intervention, in addition to assessment of risk status, include analysis of fluoride exposure and feeding practices as well as oral hygiene counseling. The early dental visit should be seen as the foundation upon which a lifetime of preventive education and oral health care can be built.

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The American Academy of Pediatric Dentistry (AAPD) intends this guideline to help practitioners make clinical decisions concerning preventive oral health

care for infants, children, and adolescents. Because each child is unique, these recommendations are designed for the care of children who have no contributory medical conditions and who are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from the normal.
- The American Academy of Pediatric Dentistry emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Chart Documentation/Checklists/Forms
Resources

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

American Academy of Pediatric Dentistry. Clinical guideline on periodicity of examination, preventive dental services, anticipatory guidance, and oral treatment for children. Chicago (IL): American Academy of Pediatric Dentistry; 2003. 3 p. [24 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2003

GUIDELINE DEVELOPER(S)

American Academy of Pediatric Dentistry - Professional Association

SOURCE(S) OF FUNDING

American Academy of Pediatric Dentistry

GUIDELINE COMMITTEE

Clinical Affairs Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Not stated

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available from the American Academy of Pediatric Dentistry Web site.

Print copies: Available from the American Academy of Pediatric Dentistry, 211 East Chicago Avenue, Suite 700, Chicago, Illinois 60611

AVAILABILITY OF COMPANION DOCUMENTS

Information about the American Academy of Pediatric Dentistry (AAPD) mission and guideline development process is available on the AAPD Web site.

The following implementation tools are available for download from the AAPD Web site:

- Dental growth and development chart
- American Academy of Pediatric Dentistry Caries-Risk Assessment Tool (CAT)

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on March 7, 2005. The information was verified by the guideline developer on April 18, 2005.

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